CITY OF SOMERVILLE, MASSACHUSETTS
JOSEPH A. CURTATONE
MAYOR

Voluntary Waiver of Health Insurance

For Enrollment in Opt-Out Program

I, ______________________, am an active employee for the City of Somerville ("City") and was covered by City's health insurance eligibility criteria that are noted # 1 and #2 of the Health Insurance Opt-Out Policy. I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the City of Somerville. Having been so advised, I do hereby waive my right to health insurance coverage through the City and I authorize the City to cancel my existing health insurance coverage as of:

Date of Voluntary cancellation: ______________________________________

- In return for my agreement to waive health insurance coverage, the City agrees to pay me on a monthly basis for a total annual payment of two thousand dollars ($2,000.00) for waiving my individual health insurance plan or four thousand ($4,000.00) for waiving my family health insurance plan, whichever applies pursuant to the City's Health Insurance Opt-Out Policy

- I acknowledge that the City of Somerville is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.

- I understand that the City of Somerville is not responsible for my medical coverage after my termination date (except for medical coverage for injuries and illnesses covered by M.G.L. c. 41, § IllF or M.G.L. c. 152) and for each fiscal year thereafter that I voluntarily agree to waive health insurance coverage through the City.

- I certify that insurance coverage is in force elsewhere for losses in regard to medical conditions for me and my dependents, if any. Additionally, I have completed and submitted the Commonwealth of Massachusetts Employee Health Insurance Responsibility Disclosure (HIRD) Form.

    - NAME OF INSURANCE CARRIER ____________________
    - GROUP NUMBER ____________________

  - NAME OF POLICY HOLDER ____________________
  - TYPE OF COVERAGE ____________________

- I hereby certify that there is no outstanding court order or agreement requiring me to provide health insurance coverage for my spouse, ex-spouse or dependent children, if any.

- I hereby acknowledge that I am only eligible to re-enroll in the City's health insurance plans during the Annual Open Enrollment Period or for a qualifying event. The qualifying events are:

  - Marriage or divorce
  - Birth or adoption of a child
  - Death of a family member
  - Lack of other coverage through no fault of the employee or subscriber
  - Change in hours, which results in change of employment status

  To reenroll, I must complete the required paperwork during the Open Enrollment period or, for a qualifying event, notify the City Personnel Department and complete the re-enrollment process within thirty (30) days of the date of loss of coverage.

  The GIC determines the effective date of when an employee will be terminated from benefits. This will coincide with the effective date of the opt-out payment to the employee.

I acknowledge that if I do re-enroll in the City's group health insurance, if my employment with the City ends, or if my hours are reduced to below 20 hours per week during the fiscal year, I will only be entitled to payment up to the month containing the date of the employee’s separation, re-enrollment or reduction of hours below 20 hours per week.

- I acknowledge that I may not participate in this plan by switching coverage to a spouse or parent, if they are also an employee of the City of Somerville or the Somerville School Department.

- I acknowledge that I have read, understand and agree to comply with the terms and conditions of the City of Somerville's Opt-Out Policy.

- The City reserves the right to modify or discontinue the program with 60 (sixty) days notice in advance of the next open enrollment with the discontinuance effective on the subsequent plan renewal date.

______________________________ ______________________________

Employee name/Employee signature William Roche, Director of Personnel

Date

Date